



HMIS Paper Discharge Form

Name _____

Birth Date: ____ / ____ / ____

*Discharge Date: ____ / ____ / ____

*Reason for Discharge

- | | | |
|--|--|---|
| <input type="radio"/> Left for a housing opportunity before completing program | <input type="radio"/> Criminal activity/destruction of property/violence | <input type="radio"/> Death |
| <input type="radio"/> Completed Program | <input type="radio"/> Reached maximum time allowed in project | <input type="radio"/> Other |
| <input type="radio"/> Non-payment of rent/occupancy charge | <input type="radio"/> Needs could not be met by project | <input type="radio"/> Unknown/Disappeared |
| <input type="radio"/> Non-compliance with project | <input type="radio"/> Disagreement with rules/persons | |

* Income Received in Past 30 Days? ☐ No ☐ Yes ☐ Don't Know ☐ Refused

If "Yes", check off all that apply and list amounts:

- | | | |
|--|--|---|
| <input type="checkbox"/> Earned Income: \$_____ | <input type="checkbox"/> Unemployment Benefits: \$_____ | <input type="checkbox"/> Veteran's Pension: \$_____ |
| <input type="checkbox"/> SSI: \$_____ | <input type="checkbox"/> SSDI: \$_____ | <input type="checkbox"/> Pension from a Former Job: \$_____ |
| <input type="checkbox"/> Veteran's Disability Payment: \$_____ | <input type="checkbox"/> Private Disability Insurance: \$_____ | <input type="checkbox"/> Alimony / Spousal Support: \$_____ |
| <input type="checkbox"/> Worker's Compensation: \$_____ | <input type="checkbox"/> TANF: \$_____ | <input type="checkbox"/> Child Support: \$_____ |
| <input type="checkbox"/> General Public Assistance: \$_____ | <input type="checkbox"/> Retirement Income from SSA: \$_____ | <input type="checkbox"/> Other: \$_____ |

* Non-Cash Benefits Received in Past 30 Days?

☐ No ☐ Yes ☐ Don't Know ☐ Refused

If "Yes", check off all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> SNAP (Food Stamps) | <input type="checkbox"/> MEDICAID health insurance | <input type="checkbox"/> Temporary Rental Assistance |
| <input type="checkbox"/> MEDICARE health insurance | <input type="checkbox"/> State Children's Health Insurance Program | <input type="checkbox"/> Other Source |
| <input type="checkbox"/> Supplemental Nutrition Program (WIC) | <input type="checkbox"/> Veteran's Administration Medical Services | |
| <input type="checkbox"/> TANF Child-Care Services | <input type="checkbox"/> TANF Transportation Service | |
| <input type="checkbox"/> Other TANF-Funded Services | <input type="checkbox"/> Section 8, Public Housing, or other ongoing rental assistance | |

Special Needs

Does the client have this condition:

If Yes, did the client receive services/treatment while in the program?

- | | | |
|------------------------------------|---|---|
| * Physical Disability: | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused | > <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused |
| * Developmental Disability: | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused | > <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused |
| * Chronic Health Condition: | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused | > <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused |
| * HIV / AIDS: | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused | > <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused |
| * Mental Health: | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused | > <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused |
| * Substance Abuse Problem: | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused | > <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused |
- If "Yes" select type: ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Drug & Alcohol Abuse

* Note: A serious disability is expected to be of a long-continued and indefinite duration and substantially impair the client's ability to live independently. The client may have special needs that do not qualify as disabling conditions.

*** New Residence Setting**

- | | |
|--|---|
| <input type="radio"/> Emergency Shelter, including hotel or motel paid for with an emergency shelter voucher | <input type="radio"/> Place not meant for habitation (e.g., vehicle, abandoned building, bus/train station or anywhere outside) |
| <input type="radio"/> Transitional housing for homeless persons | <input type="radio"/> Safe Haven |
| <input type="radio"/> Permanent supportive housing for formerly homeless persons | <input type="radio"/> Rental by Client, with Veterans Admin housing subsidy (VASH) |
| <input type="radio"/> Psychiatric hospital or other psychiatric facility | <input type="radio"/> Rental by Client, with other housing subsidy (non-VASH) |
| <input type="radio"/> Substance abuse treatment facility or detox center | <input type="radio"/> Rental by client, no housing subsidy |
| <input type="radio"/> Hospital (non-psychiatric facility) | <input type="radio"/> Owned by client, with housing subsidy |
| <input type="radio"/> Jail, prison or juvenile detention facility | <input type="radio"/> Owned by client, no housing subsidy |
| <input type="radio"/> Staying or living in a family member's room, apartment, or house | <input type="radio"/> Other |
| <input type="radio"/> Staying or living in a friend's room, apartment, or house | <input type="radio"/> Deceased |
| <input type="radio"/> Hotel or motel paid for without emergency shelter voucher | <input type="radio"/> Don't Know |
| <input type="radio"/> Foster care home or foster care group home | <input type="radio"/> Refused |

***Housing Status at Discharge:**

- | | |
|---|-------------------------------------|
| <input type="radio"/> Literally Homeless | <input type="radio"/> Stably Housed |
| <input type="radio"/> Imminently losing their housing | <input type="radio"/> Don't Know |
| <input type="radio"/> Unstably Housed and at-risk of losing their housing | <input type="radio"/> Refused |

***New Residence County:**

- ☐ Indiana County: _____

- ☐ Outside Indiana

- ☐ Unknown

City/Town of New Residence: _____

Township of New Residence: _____

Employed at Time of

Discharge:

- ☐ Yes
☐ No

Enrolled in School

at Time of Discharge:

- ☐ Yes
☐ No

Highest Level of School

Completed at Dishcharge:

- ☐ No schooling completed
☐ Nursery school to 4th grade
☐ 5th or 6th grade
☐ 7th or 8th grade
☐ 9th grade
☐ 10th grade
☐ 11th grade
☐ 12th grade - No Diploma
☐ High School Diploma
☐ GED
☐ Post-Secondary School

Outcome Category:

- ☐ Graduation
☐ Service Refusal / Drop Out
☐ Transfer to Similar Program
☐ Medical Complications / Deceased
☐ Suicide
☐ Other Neutral
☐ Other Negative
☐ Incarceration
☐ Long-term Psych. Hospitalization

Discharged To: _____

(In HPRP Programs, please list the client's new address and phone number).

Discharge Summary: (describe why the client was discharged)

This form may be modified to add additional questions, however the content of the existing questions should not be changed.
Instructional material and definitions for all questions can be found on our website: <http://www.in.gov/ihcda/3120.htm>